NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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NHS England

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Via email

Prof Chris Welsh

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9th September 2024

Dear Simon and Michelle,

Senate Review of Proposed Aortic Dissection Rota

Thank you for the opportunity to revisit your proposals for a Yorkshire wide Aortic Dissection rota. In 2019 the Clinical Senate undertook a review of the plans for a Yorkshire and Humber-wide acute aortic dissection rota, the implementation of which was interrupted due to the global pandemic. The Senate was presented with plans for a rota involving Hull and East Yorkshire Hospitals NHS Trust and Sheffield Teaching Hospital NHS Foundation Trust.

The objectives of this review are for the Senate to provide you with independent clinical oversight of the proposed clinical model ahead of its implementation. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion during Augst 2024 are listed within the Terms of Reference enclosed with this letter. Thank you for your valuable time in presenting the plans and answering questions with the review team on 28 August 2024 which improved our understanding of the proposals and the great deal of work that has been undertaken to bring the plans to the point of implementation.

In summary your proposal is that all patients with acute aortic dissection in Hull, East Yorkshire and Sheffield areas will be operated on by an experienced and specialist surgeon which requires a dedicated acute aortic rota with one hospital, with a specialist surgeon on call, taking all patients with aortic dissection.

The questions you asked us to consider are:

- Is the proposal clinically acceptable?
- Are the risks associated with additional travel mitigated by providing best practice?

I hope this letter provides a constructive summary of our comments and advice.

Question 1 – Is the proposal clinically acceptable?

The Senate is strongly supportive of your proposals for the aortic dissection rota and agrees that these are clinically appropriate. The Senate believes that implementing the rota that would ensure all patients requiring surgery are always treated by suitably experienced cardiothoracic surgeons is the right thing to do. We also felt that the implementation of a rota that creates a distinctive team would be the right thing to do for the staff.

The information the Senate received indicated that the plans are in line with the recommendations in the GIRFT Programme National Specialty Report on Cardiothoracic Surgery published in March 2018 which recommends the creation of rotas of specialist surgeons allied to networks of referring hospitals to cover geographic areas. The report also recommends the establishment of formal agreements between referring hospitals, receiving specialist units and ambulance services for transfer of Acute Aortic Dissection (AAD) patients to the relevant specialist centre and that these arrangements should include a dedicated phone number for referrals and service co-ordination.

In relation to the operational implementation of the rota, the expert panel members had some caveats, having not seen any detailed standard operating procedures that describe what would happen, minute by minute in order to be assured that the patient's journey through the system would be speedy and efficient. However, the panel understood that those standard operating procedures are being developed and will contain sufficient detail so that all key services and personnel are aware of what needs to happen, how and when.

The Senate understands that the principles behind a proposal such as this is that there will be fewer surgeons carrying out all the aortic dissection surgical procedures such that they become more familiar, take a standardised approach, reduce variation in practice and there is equity of access and improved outcomes for patients. To achieve this there is a minimum number of procedures a dedicated aortic dissection team needs to carry out which, per other centres in the UK, is 10-12 elective complex aortic procedures and 5-6 aortic dissection operations per surgeon and surgical team, per year. The Senate recognised that to get to this minimum level of procedures will require time but that to embark on the journey to achieve this was the right thing to do if there was confidence that the critical mass of numbers of procedures carried out could be achieved over time.

The Senate heard that between Hull and Sheffield hospitals there are currently 38 aortic dissections carried out and that this is increasing every year. There are four aortic surgeons at Sheffield and three at Hull which would provide a sustainable, dedicated aortic dissection rota with approximately, and at least, five to six acute aortic dissections carried out per surgeon per year but with significant increases in numbers expected over the next few years due to improved pathways and education.

In relation to education and training it is suggested that it would be beneficial if a second aortic surgeon 'scrubs-in' when possible. This would be the means to standardise surgical approaches and to ensure the number of operations per surgeon during the initial stages of implementation or when new members join the team.

The Senate panel members were pleased to hear about your plans for the governance of the implementation of the aortic dissection toolkit with quarterly governance meetings at which the standard operating procedures will be reviewed and best practice and learning will be shared. It was also good to hear about your plans for an ad hoc, out of hours multidisciplinary team meeting to ensure all relevant and on-call aortic dissection clinicians can attend a virtual meeting to make informed and timely decisions about patient care. However, we did hear that the systems and information governance processes for sharing and transferring high quality CT images from emergency departments to either Hull or Sheffield is yet to be fully resolved, although a solution is actively being sought.

Question 2 - Are the risks associated with additional travel mitigated by providing best practice?

The Senate panel understands that the delays in the current patient pathway are primarily due to the time taken to diagnose AAD patients. You explained that the average time between a patient presenting to an emergency department to undergoing surgery for aortic dissection is 6 hours. Diagnosis can take several hours especially if the diagnosis is not considered at an early stage and your use of the Think Aorta educational materials amongst clinical teams to reduce the time to diagnose is positive.

We were pleased to hear about the additional steps you have undertaken to ensure that the two ambulance services involved with this proposal can swiftly navigate the hospital sites to ensure a patient is quickly brought to the correct location.

We fully recognise the importance of the patient moving as quickly as possible from presentation to surgery to improve the patients' chance of survival, but we agree that the risks of the additional travel should be mitigated by the improved pathway brought about by this change, including the improvements in time to diagnosis and the single point of contact leading to rapid transfer.

Recommendations

Having reviewed the information provided to the Senate and after the discussions in August 2024 the expert panel members make the following recommendations.

During our discussions it was evident that much work had taken place in developing the standard operating procedures (SOP) and that thought had gone into some of the detail. However, we were not able to review the SOPs as they were not yet finalised despite a go-live date for the rota having been agreed.

Recommendation: To finalise your internal standard operating procedures and put them in place as quickly as possible.

The previous (2019) Senate review of these proposals included Leeds hospital as a third centre involved with the provision of the region-wide AAD rota. The Senate panel understood that at this time Leeds would not be participating in the rota.

Recommendation: There would be benefits to the Yorkshire and Humber system if Leeds were to join the rota on a level playing field and this would be strongly encouraged.

As the numbers of patients involved in this service increase there will be a need to ensure that plans are developed and put in place to ensure a smooth repatriation process back to the local hospital for rehabilitation.

Recommendation: The plans for repatriation of patients requires further development to ensure that this is a clear, smooth and efficient aspect of the service.

Timely access to patient images and information is crucial in a time critical patient pathway and the panel members heard about some challenges to accessing patient records and images from other sites.

Recommendation: Having greater connectivity and access to each site's patient records is imperative and we recommend that this is pursued and resolved as soon as possible.

We were pleased to hear of your plans for ongoing clinical governance of the SOPs and your recognition of the need to make adjustments and refinements to ways of working as time progresses. Continuous and ongoing audit for this new rota needs to include all patients from the start; from the point of query AAD in the ED, so that any delays in definitive tests and issues with transit for example can all be monitored, to include patients who are diagnosed but do not make it to surgery. Your audit should also measure surgical outcomes in each of the operating units. We acknowledge that there may be an increase in mortality in the early periods of this new pathway because of its success in allowing more patients make it to surgery, who previously would have died without surgery.

Recommendation: The Senate strongly recommends full and transparent continuous quality assurance through a programme of transparent audit of all patients discussed.

Conclusion

The Senate is strongly supportive of your proposals for the aortic dissection rota and agrees that these are clinically appropriate. We agree with the proposals to require surgery to be always undertaken by experienced cardiothoracic surgeons and agree that the risks of the additional travel should be mitigated by the improved pathway brought about by this change.

Our recommendations in relation to this include finalising the detail of the SOPs and repatriation plans, the requirement for comprehensive audit and better connectivity and data sharing agreements. We would also recognise the benefits to the Yorkshire and Humber system should Leeds participate in the rota.

We hope our comments are helpful to you.

Yours sincerely

Chris Welsh
Senate Chair
Yorkshire and Humber Clinical Senate

Yorkshire and the Humber
Clinical Senate

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CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Acute Aortic Dissection Rota - Yorkshire

Sponsoring Organisation: NHS England Specialist Commissioning – NW Region

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Simon Kendall, MD Specialised Commissioning, NW Region

Date: 29/07/2024

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1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh

Clinical Senate Review Team Members:

Dr John Bourke, Consultant Cardiologist, Newcastle Hospitals NHS Foundation Trust

Mr Stephen Edmundson, Consultant Cardiothoracic Surgeon, Clinical Director for Cardiac and Thoracic Surgery, Barts Health NHS Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Is the proposal clinically acceptable? Are the risks associated with additional travel mitigated by providing best practice?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

To provide advice to NHS England, North, Specialised Commissioning (Yorkshire and the Humber), Hull and East Yorkshire Hospitals and Sheffield Teaching Hospitals in the development of their proposals. The advice will inform the next steps in implementing the aortic dissection service

Scope of the review

The review will focus on the above questions using the written evidence provided to the panel supplemented by discussion between the panel and the clinical and commissioning leads.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 23/07/2024

Agree the Terms of Reference: 29/07/2024

Receive the evidence and distribute to review team: 29/07/2024

Teleconferences: 28/08/2024

Draft report submitted to commissioners: 05/09/2024

Senate Council ratification; 26/09/2024

Final report agreed: 26/09/2024

Publication of the report on the website: 27/09/2024

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring organisation and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

Aortic Dissection Toolkit

Audit of cases

Copy of presentation to staff and evidence of support from Aortic dissection Trust and Charities

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the sponsoring organisation, NHS England and NHS Improvement (if this is an assurance report) and made available on the Senate website. Publication will be agreed with the commissioning sponsor.

The publication date will be agreed with the sponsoring organisation during the development of these terms of reference. It is expected that the report will be published soon after its agreement and at the latest 8 weeks followings its sign off by the Council (ie by the next Council meeting following its ratification)

8. EVALUATION

The Senate will ask the sponsoring organisation to contribute to a Case Study to help summarise the work undertaken and assess the impact of the Senate advice. This will be emailed to the named organisational lead following the publication of the report with a request for an evaluation of our impact, a testimonial and suggestions as to how we may improve our processes.

9. RESOURCES

The Yorkshire and the Humber clinical Senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

10. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

The review report may be used by NHS England and NHS Improvement in their formal service change assurance process.

11. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England and NHS Improvement for inclusion in its formal service change assurance process if applicable
v. complete the Case Study and request for evaluation issued by the Senate after the publication of the Senate report.

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review the draft report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END